NC DMA Pharmacy Request for Prior Approval - Triptans

Recipient Information **DMA-0023**

1. Recipient Last Name:_____ 2. First Name:_____
3. Recipient ID #_____ 4. Recipient Date of Birth:_____ 5. Recipient Gender:_____

Payer Information

6. Is this a Medicaid or Health Choice Request? Medicaid: ☐ Health Choice: ☐

Prescriber Information

7. Prescribing Provider #:_____ NPI: ☐ *or* Atypical: ☐
8. Prescriber DEA #: _____
Requester Contact Information Name:_____Phone #:_____Ext:_____

Drug Information

9a. Drug Name: _____ 9b. Is this request for a Non-Preferred Drug? ☐ Yes ☐ No
10. Strength: _____ 11. Quantity Per 30 Days: _____
12. Length of Therapy (in days): ☐ up to 30 ☐ 60 ☐ 90 ☐ 120 ☐ 180 ☐ 365 ☐ Other:_____

Clinical Information

Request for Non-Preferred Drug:

1. ☐ Failed two preferred drug(s). List preferred drugs failed: _____
   1a. ☐ Allergic Reaction 1b. ☐ Drug-to-drug interaction. Please describe reaction: _____
2. ☐ Previous episode of an unacceptable side effect or therapeutic failure. Please provide clinical information:
_____
3. ☐ Clinical contraindication, co-morbidity, or unique patient circumstance as a contraindication to preferred drug(s).
Please provider clnicial information: _____
4. ☐ Age specific indications. Please give patient age and explain: _____
5. ☐ Unique clinical indication supported by FDA approval or peer reviewed literature. Please explain and provide a general reference:
_____
6. ☐ Unacceptable clinical risk associated with therapeutic change. Please explain: _____

Request for Exceeding Quantity Limit (Check all that apply.)

7. Does the patient have a diagnosis of migraine or cluster headache? ☐ Yes ☐ No
8. Does the patient have more than 6 moderate or severe headache days per month? ☐ Yes ☐ No
9. Does the patient have a history of NSAID therapy in the past year? ☐ Yes ☐ No
10. Does the patient have a contraindication or allergy to NSAID therapy? ☐ Yes ☐ No
11. Is the patient currently receiving therapy with a migraine preventative? ☐ Yes ☐ No
12. Does the patient have a contraindication or history of an adverse reaction with preventative medications? ☐ Yes ☐ No
Please list: _____
13. Did the patient have no clinical benefit after at least a 90 day trial of preventative medications at the maximum tolerated dose? ☐ Yes ☐ No
14. Has the patient been diagnosed with Ischemic Heart Disease, Peripheral Vascular Disease, Cerebrovascular Disease, Ischemic Bowel Disease, or Hemiplegic Migraine? ☐ Yes ☐ No
15. Has the patient received an MAO Inhibitor in the past 2 weeks? ☐ Yes ☐ No
16. Has the patient received an ergot medication in the past 24 hours? ☐ Yes ☐ No
17. Does the patient have uncontrolled hypertension or basilar migraine? ☐ Yes ☐ No
18. Has the prescriber reviewed the DMA evidenced-based recommendations on the treatment of migraine? ☐ Yes ☐ No

I certify that the information provided is accurate and complete to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.

Signature of Prescriber:_____ Date:_____

*Prescriber signature mandatory

Fax this form to CSC at: (855) 710-1964 Pharmacy PA Call Center: (866) 246-8505

Instructions for completing this form can be found at http://www.NCTracks.com/PAformhelp V.01